Supreme Court, U.S.
FILED
JAN 16 1996
OFFICE OF THE CLERK

NO. 95-1194

IN THE SUPREME COURT OF THE UNITED STATES

OCTOBER TERM, 1995

CHERYL M. PELOQUIN,

Petitioner,

vs.

UNITED OF OMAHA LIFE INSURANCE COMPANY, a Nebraska corporation,

Respondent.

APPEAL FROM A JUDGMENT OF THE CIRCUIT COURT OF THE 17TH JUDICIAL CIRCUIT IN AND FOR BROWARD COUNTY, FLORIDA, IN THE DISTRICT COURT OF APPEAL OF FLORIDA, FOURTH DISTRICT

PETITION FOR WRIT OF CERTIORARI

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28 pp

QUESTIONS PRESENTED FOR REVIEW

I. WHERE THE STANDARD OF REVIEW TO BE APPLIED RESPECTING AN ACTION CREATED AND GOVERNED BY A FEDERAL STATUTE HAS BEEN DETERMINED BY THE UNITED STATES SUPREME COURT, MAY A STATE COURT PROPERLY APPLY A CONTRARY STANDARD OF REVIEW.

II. MAY AN APPELLATE COURT ASSUME THAT THE WRONG STANDARD OF REVIEW WAS APPLIED IN THE LOWER COURT WHERE NO STANDARD WAS ARTICULATED IN THE JUDGMENT UNDER REVIEW.

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OPINIONS AND ORDERS

The Opinion of the District Court of Appeal of Florida, Fourth District is reported as United of Omaha v. Peloquin, 660 So.2d 1069 (Fla. 4th DCA 1995) Rehearing denied, October 17, 1995, and is contained in the Appendix at pages 1-7.

An Order denying a Motion for Rehearing/Motion for Rehearing En banc is reported as United of Omaha v. Peloquin, 660 So.2d 1069 (Fla. 4th DCA 1995) Rehearing denied, October 17, 1995, and is contained in the appendix at page 8. These are the only reported decisions.

An unreported Final Judgment from the Seventeenth Judicial Circuit in and for Broward County, Florida is contained in the Appendix at page 9-12.

CONCISE JURISDICTIONAL STATEMENT

The Opinion of the District Court of Appeal of Florida, Fourth District, upon which review is sought, is dated August 2, 1995. A request for Rehearing/Rehearing En banc was denied by Order dated October 17, 1995. The said Opinion and Order denying Rehearing/Rehearing En banc was rendered by the "state court of last resort" as contemplated by Sup. Ct. R. 13. This Petition was timely filed within 90 days of the date of the Order denying the Motion for Rehearing/Rehearing En Banc. Jurisdiction of this Court is invoked under 28 U.S.C. Section 1257(a).

STATUTES

The Employee Retirement Income Security Act of 1974 (ERISA) 29 U.S.C. Section 1001 et. seq., specifically 29 U.S.C. Section 1132(a)(1)(B).

> (a) Persons empowered to bring a civil action. A civil action may be brought--
>
> (1) by a participant or beneficiary--
>
> (A) for the relief provided for in subsection (c) of this section, or
>
> (B) to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan;

STATEMENT OF THE CASE

The United States Supreme Court in Firestone Tire and Rubber Co. v. Bruch, 489 U.S. 101, 109 S.Ct. 948, 103, L.Ed.2d 80 (1989), determined that whenever a benefit plan falling within the purview of the Employee Retirement Income Security Act of 1974, 29 U.S.C. Section 1001, et. seq. (hereafter "ERISA"), gives the administrator discretionary authority to determine eligibility for benefits or to construe the terms of the plan, a trial court is to review the administrator's denial of a claim for benefits under an 'arbitrary and capricious' standard.

The concerned ERISA Plan gave discretionary authority to UNITED to interpret the terms of the plan and to deny benefits as follows:

> AUTHORITY TO INTERPRET POLICY:
> By purchasing (this policy) or (these

> policies), the policyholder grants (United of Omaha Life Insurance Company) or (Mutual of Omaha Insurance Company) the discretion and the final authority to construe and interpret the (Policy) or (Policies). This means that (United) or (Mutual) has the authority to decide all questions of eligibility and all questions regarding the amount and payment of any Policy benefits within the terms of the (Policy) or (Policies) as interpreted by (United) or (Mutual). In making any decision, (United) or (Mutual) may rely on the accuracy and completeness of any information furnished by the policy holder or an insured person. (United) or (Mutual) interpretation of the (policy) or (policies) as to the amount of benefits and eligibility shall be binding and conclusive on all persons.

The issue of the standard to be applied by the Circuit Court of the Seventeenth Judicial Circuit in and for Broward County, Florida (the trial court) upon its review of the Plan administrator's denial

of benefits was not directly raised or addressed by either party. [1]

The question of the applicable standard of review (the federal question herewith concerned) was first raised by the appellee on the appeal before the District Court of Appeal of Florida, Fourth District. (See Appendix page 6). The court of appeal determined that there was:

> no indication that the trial court considered, or was asked to consider, the denial of th[e] claim on any basis other than by interpreting the policy and applying the stipulated facts...

and the appellate court reviewed the matter without reference to application of the standard of

---

[1] The only reference by either party respecting "standard of review" was with regard to review of the Plan wording and not review of the denial of benefits quoting Boland v. King County Medical Blue Shield, 798 Fed. Supp. 638, 646 (W.D. Wash., 1992) and was contained in Plaintiff's Motion for Summary Judgment.

review mandated by Firestone, supra. (See Opinion, last paragraph, in Appendix, page 6).

ARGUMENT

The Petition sub judice should be granted:

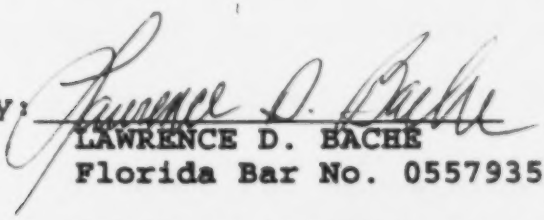
BECAUSE to countenance contempt, or even the appearance of contempt, by a state court for any pronouncement of the highest court in the land respecting administration of the law, would be to undermine and put in disarray the nation's entire system of justice. A fortiori where the pronouncement flouted was with respect to a federal statute. The District Court of Appeal of Florida, Fourth District, in the instant case not only disregarded the determination of this court as to the applicable standard of review, but went so far as to suggest that the issue was still open for resolution. (Appendix page 6).

BECAUSE any decision of a state court in de facto derogation of this Court's authority, if unrepudiated and unaddressed, undermines public confidence in the competence of the judiciary as a whole. The concerned opinion is manifestly such a decision.

BECAUSE The District Court of Appeal of Florida, Fourth District's failure to apply the maxim omnia praesumunter rite esse acta in the absence of a statement by the lower court as to the standard of review it was applying is in diminishment of the competence of that court and thus constitutes a threat to the common weal.

FOR THESE REASONS Certiorari should issue herein.

Respectfully submitted this 12 day of January, 1996

By: 
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CERTIFICATE OF SERVICE

I HEREBY CERTIFY that a true and correct copy of the foregoing was served by U.S. Mail this 12 day of January, 1996 upon:

R. Fred Lewis, Esq.
KUVIN LEWIS RESTANI & STETTIN, P.A.
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NO. _____

IN THE SUPREME COURT OF THE UNITED STATES

OCTOBER TERM, 1995

CHERYL M. PELOQUIN,

Petitioner,

vs.

UNITED OF OMAHA LIFE
INSURANCE COMPANY,
a Nebraska corporation,

Respondent.

APPENDIX TO PETITION FOR WRIT OF CERTIORARI

IN THE DISTRICT COURT OF APPEAL OF
THE STATE OF FLORIDA FOURTH DISTRICT,
JULY TERM 1995

UNITED OF OMAHA LIFE INSURANCE CO., a Nebraska corporation,

Appellant(s)

vs.

CHERYL M. PELOQUIN, et. al.,

Appellees(s)

CASE NO. 94-0163

L.T. CASE NO. 92-13834 09 BROWARD

Opinion filed August 2, 1995

Appeal from the Circuit Court for Broward County; Lawrence Korda, Judge

R. Fred lewis of Magill & Lewis, P.A., Miami, for appellant.

Lawrence D. Bache of Law Office of Lawrence D. Bache, Pembroke Pines, and Roy Taylor, Miami, for Appellee - Cheryl M. Peloquin

STONE, J.

We reverse a final judgment entered in favor of the insured, Peloquin, against the insurer, United of Omaha, for wrong-

fully denying her benefits for treatment of a medical condition, endometriosis of the colon. The insurer denied payment for the treatment, as not covered under the terms of its group policy, because the insured was receiving medical care for the condition at the time she applied for the policy. After denying cross motions for summary judgment, the court conducted a final hearing at which no evidence was presented by either side, both relying on the depositions and affidavits of record.

The policy contains a pre-existing conditions rider which defines a preexisting condition as:

> a condition for which treatment or services were [sic] received or prescribed drugs or medicines were taken within 180 days prior to the date the person was insured under this Master policy ...
>
> ***
>
> All related conditions shall be considered to be one injury or sickness.

In the "definitions" portion of the policy, the term "sickness" is defined as:

> a disease, disorder or condition (including complications of pregnancy) which requires treatment by a physician....

By her signature on the application, Peloquin agreed that she understood the following:

> This (policy/certificate) has a pre-existing condition limitation and if a physician has provided treatment or recommended treatment for any injury or illness or other condition within the six-month period prior to issuance of the (policy/certificate) for which I am applying, no coverage will be provided for that illness or injury or other condition until six months after the (policy/certificate) has been issued.

The depositions and affidavits reflect that the insured was being treated in June of 1990 for severe abdominal pain, the cause of which was, at the time, unknown. She was referred to a specialist and a colonoscopy was performed in August

leading to a September surgery and biopsy which revealed that the problem was an obstruction caused by the endometriosis. The medical testimony is unrefuted that the abdominal paid for which the insured was being treated prior to applying for the policy was caused by the endometriosis condition first diagnosed after the policy was in effect.

In Life General Security Ins. Co. v. Cook, 648 So.2d 237 (Fla. 4th DCA 1994), a case not available to the trial court, we recognized that a similar policy exclusion precluded coverage where the insured was being treated for a previously undiagnosed illness and the evidence was undisputed that the preexisting symptoms for which treatment was being sought were caused by the illness for which the insured was seeking coverage. We recognize that the policy at issue in Cook defined pre-exist-

ing conditions to include any conditions for which symptoms were evident. However, we do not consider this distinction to be significant, as the policy in the instant case included in its definition of pre-existing condition all conditions related to those for which treatment was previously sought.

The insured has failed to demonstrate that she is entitled to benefits under the policy. We understand the trial court's reluctance to deny coverage based on a condition as common as abdominal pain. However, the insured points to no evidence that the pain for which she was being treated might have been related to any condition other than that finally diagnosed, albeit after the coverage commenced. The unrefuted testimony is that the endometriosis condition was present at all relevant times and was the cause of

the pain for which she was receiving ongoing treatment and diagnosis at the time of her application.

The trial court apparently resolved this issue through a de novo review. Appellee asserts that since the group policy is governed by the Employee Retirement Income Security Act (ERISA Sec. 402-(b)(3), the issue should have been whether there was an abuse of discretion by the plan administrator; in this case the insurer. However, there is no indication that the trial court considered, or was asked to consider, the denial of this claim on any basis other than by interpreting the policy and applying the stipulated facts on the merits of the insured's claim. Therefore, we have reviewed the trial court decision on the basis presented to it, without deciding whether, in similar cases the coverage issue should be

resolved by finding whether the administrator's decision was arbitrary.

Therefore, the final judgment is reversed.

PARIENTE, J. and BROWN, LUCY, Associate Judge concur.

IN THE DISTRICT COURT OF APPEAL OF
THE STATE OF FLORIDA FOURTH DISTRICT,
P.O. BOX 3315, WEST PALM BEACH, FL 33402

UNITED OF OMAHA LIFE INSURANCE CO., etc.
Appellant(s)

CASE NO. 94-00163

vs.

CHERYL M. PELOQUIN, et. al.,
Appellees(s)

L.T. CASE NO. 92-13834 09 BROWARD

October 17, 1995

BY ORDER OF THE COURT:

ORDERED that appellee's motion filed August 17, 1995, for rehearing/motion for rehearing en banc is hereby denied.

I hereby certify the foregoing is a true copy of the original court order.

MARILYN BEUTTENMULLER
CLERK

cc: R. Fred Lewis
Lawrence D. Bache
Frederick C. Sake
Roy Lloyd Taylor

IN THE CIRCUIT COURT OF THE SEVENTEENTH JUDICIAL CIRCUIT, IN AND FOR BROWARD COUNTY, FLORIDA

CASE NO. 92-13834 (09)

CHERYL M. PELOQUIN,

Plaintiff,

v.

UNITED OF OMAHA LIFE INSURANCE COMPANY, a Nebraska corporation, and UNIVERSITY DENTAL HEALTH CENTER, INC., a Florida corporation,

Defendants.

_____/

FINAL JUDGMENT AGAINST UNITED OF OMAHA LIFE INSURANCE COMPANY

THIS ACTION was tried before the Court after due notice to all parties. The Plaintiff and Defendant, UNITED OF OMAHA LIFE INSURANCE COMPANY, were present and both were represented by counsel. Defendant UNIVERSITY DENTAL HEALTH CENTER, INC. did not participate in this trial. Based upon the evidence and testimony pre-

sented, the Court finds in favor of the Plaintiff and against the Defendant UNITED OF OMAHA LIFE INSURANCE COMPANY. It is, therefore,

ORDERED AND ADJUDGED as follows:

1. That the Plaintiff, CHERYL M. PELOQUIN, is covered under the governing group health policy, and does have and recover from the Defendant, UNITED OF OMAHA LIFE INSURANCE COMPANY, the principal sum of Twenty Eight Thousand Three Hundred Sixteen and 73/100 Dollars ($28,316.73) which shall bear interest at the rate of 12% per annum, for all of which let Execution issue forthwith.

2. That Plaintiff incurred Sixty Three Thousand Eight Hundred Ninety Five and 82/100 Dollars ($63,895.82) in medical expenses while covered under the governing group health policy, of which Thirty Five Thousand Five Hundred Seventy Nine and

09/100 Dollars ($35,579.09) has been paid. In the event that the Plaintiff is required to reimburse payment of the said Thirty Five Thousand Five Hundred Seventy Nine and 09/100 Dollars ($35,579.09), Defendant UNITED OF OMAHA LIFE INSURANCE COMPANY shall be liable to furnish said sum to the Plaintiff or to make payment directly to the party or parties claiming reimbursement.

3. The Court retains jurisdiction to determine the recoverable attorney's fees and costs.

4. The Court retains jurisdiction of this cause as it relates to Plaintiff's claims against Defendant UNIVERSITY DENTAL HEALTH CENTER.

5. The Plaintiff and Defendant UNITED OF OMAHA LIFE INSURANCE COMPANY stipulate, in the event an appeal is taken, that no appellate bond is required to

be posted by UNITED OF OMAHA LIFE INSURANCE COMPANY.

DONE AND ORDERED in Fort Lauderdale, Broward County, Florida, this _____ day of _____ 1993.

LAWRENCE L. KORDA JAN 3 1994
CIRCUIT COURT JUDGE

Copies furnished:
Lawrence D. Bache, Attorney for Plaintiff
Frederick C. Sake, Esq., Attorney for Defendant, UNIVERSITY,
Peter Restani, Esq., Attorney for Defendant, UNITED

Supreme Court, U.S.
FILED
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No. 95-1194

In The

Supreme Court of the United States

October Term, 1995

CHERYL PELOQUIN,

Petitioner,

vs.

UNITED OF OMAHA LIFE INSURANCE COMPANY, a Florida corporation,

Respondent.

On Petition For Writ Of Certiorari To The District Court Of Appeal Of The State Of Florida For The Fourth District

RESPONDENT'S BRIEF IN OPPOSITION

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February, 1996

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RESTATEMENT OF JURISDICTIONAL QUESTIONS PRESENTED

I

WHETHER A FULL DECISION FROM AN INTERMEDIATE APPELLATE COURT CONSTITUTES A REVIEWABLE FINAL JUDGMENT RENDERED BY THE HIGHEST COURT IN WHICH A DECISION COULD BE HAD IN FLORIDA?

II

WHETHER A DECISION OF A STATE INTERMEDIATE APPELLATE COURT WHICH APPLIED CONTRACTUAL LANGUAGE TO UNREFUTED EVIDENCE GENERATES A BASIS FOR CERTIORARI REVIEW WHERE THE STANDARD OF REVIEW APPLIED WAS REQUESTED BY THE COMPLAINING PARTY, AND THE STANDARD OF REVIEW IS IRRELEVANT TO THE ACTUAL DETERMINATION?

LIST OF ALL PARTIES TO THE PROCEEDING

Counsel for Respondent certifies to the Court that the following persons are parties to or have an interest in the outcome of the litigation.

Lawrence D. Bache, Esq.
Counsel of Record for Petitioner

Kuvin, Lewis, Restani & Stettin, P.A.
Trial Attorneys for Defendant

Law Office of Lawrence D. Bache
Trial Attorneys for Plaintiff

R. Fred Lewis, Esq.
Counsel of Record for Respondent

CHERYL M. PELOQUIN
Plaintiff/Appellee/Petitioner

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Trial counsel for Defendant

Frederick C. Sake, Esq.
Trial counsel for Defendant, University Dental

University Dental Health Center, Inc.
Defendant/Appellee/PELOQUIN'S employer

UNITED OF OMAHA LIFE INSURANCE
Defendant/Appellant/Respondent

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RESPONDENT'S BRIEF IN OPPOSITION

The Respondent, UNITED OF OMAHA LIFE INSURANCE COMPANY, respectfully requests that this Court deny the Petition for Writ of Certiorari, which seeks review of the decision of an intermediate Florida appellate court rendered by the District Court of Appeal, Fourth District of Florida, reported at 660 So.2d 1069 (Fla. 4th DCA 1995). The Petitioner did not exhaust her state appellate remedies and presented nothing to the Florida Supreme Court as permitted by the Florida Constitution and the Florida Rules of Appellate Procedure.

The litigation involved a claim by CHERYL M. PELOQUIN for insurance benefits for the treatment of a medical condition that pre-existed the issuance of an insurance contract for which no benefits were due. The Petitioner was the plaintiff in the trial court, the appellee in the district court of appeal, and will be referred to herein as "PELOQUIN." The unrefuted testimony demonstrated that condition for which PELOQUIN sought insurance benefits was a condition for which she had been treated prior to the existence of the insurance contract.

The Respondent, UNITED OF OMAHA LIFE INSURANCE COMPANY, was the defendant in the trial court, the appellant in the district court of appeal, and will be referred to in this brief as "UNITED."

RESTATEMENT OF THE CASE

A. Overview – No Jurisdiction.

The present case seeks review of a decision from an intermediate appellate court in Florida which is not "the highest court" of Florida "in which a decision could be had" in connection with this litigation. The Florida Constitution and the Florida Rules of Appellate Procedure provide a method for seeking review of decisions such as that involved in the present case by the Florida Supreme Court. The documents filed with this Court facially demonstrate that PELOQUIN failed to exhaust state appellate remedies and failed to seek review, as is required as a condition precedent to certiorari review in this Court, under the circumstances presented. The failure to seek discretionary review in the Florida Supreme Court renders the present proceedings objectionable, and this Court without jurisdiction.

Additionally, the decision below does not create a special or important basis for jurisdiction to be exercised. The determination did not involve the validity of any treaty or statute of the United States or of any state, and was not determined based upon any right or privilege claimed under any constitution or statute. The decision does not create conflict with any principle of law enunciated by either this Court or any other state or federal appellate court. The decision below does not set forth or involve any principle of law important to the public generally, nor has any conflict of opinion or authority been created.

PELOQUIN ignores the status of the evidence and the position asserted by PELOQUIN in the trial court.

Further, the decision below facially sets forth that the court applied the standard requested by PELOQUIN in reaching its determination, without establishing a decision based upon an independent federal issue or question. Finally, PELOQUIN continues to ignore that she could not and did not satisfy any burden of proof demonstrating entitlement to insurance benefits because no matter what standard would be applicable, the unrefuted evidence demonstrated that PELOQUIN was receiving medical treatment prior to the issuance of an insurance policy. The standard applied by the trial court, as specifically requested by PELOQUIN, was the most favorable to PELOQUIN, and a substantially lighter burden than PELOQUIN suggests to be applicable as an afterthought. If PELOQUIN could produce no evidence to support an entitlement to benefits, then she certainly did not and could not satisfy a burden of proof in demonstrating that the refusal of benefits constituted an arbitrary and capricious act.

B. Statement of Case and Facts.

The Petitioner fails to present the case and facts involved in this litigation. PELOQUIN initiated this litigation against both UNITED and her employer, University Dental Health Center, Inc. PELOQUIN asserted that her employer had improperly permitted health insurance coverage to terminate June 1, 1990 based upon the employer's failure to pay premiums. After a 45 day lapse in health insurance coverage, coverage was sought with a

different company, and based upon applications submitted to a different company on June 15, 1990, UNITED provided a health insurance contract.

PELOQUIN requested insurance benefits for treatment of endometriosis of the colon, which was denied by UNITED because PELOQUIN was receiving medical care for the condition at the time she applied for the policy. PELOQUIN initiated this litigation and in a third amended complaint asserted that she was entitled to recover for medical treatment and there was a dispute with regard to a pre-existing condition in connection with such insurance coverage. The insurance contract contained a pre-existing condition limitation which provided that no benefits would be payable in connection with any condition for which an insured had received treatment or services, or received drugs or medicines within 180 days prior to the date of the policy. The unrefuted evidence demonstrated that PELOQUIN was receiving active medical care before she submitted her application for insurance to UNITED, which included treatment by physicians, medication, hospital involvement, and a recommendation for further medical intervention. PELOQUIN concealed all information in the application submitted to UNITED for insurance, and did not even disclose consultations with any physicians for her abdominal problems.

PELOQUIN asserted in the trial court that she was entitled to a *de novo* review of the denial of insurance benefits. Based upon PELOQUIN's trial court position, the trial court applied the facts presented to the insurance contract and determined that PELOQUIN was entitled to benefits. UNITED sought review in the District Court of

Appeal, Fourth District of Florida, which rendered its decision holding that where the unrefuted medical evidence demonstrated that the insured was receiving active treatment for a condition at the time the insurance contract was issued, such constituted a pre-existing condition under the terms of the applicable insurance contract where the condition existed prior to the issuance of the insurance contract but the name of the condition was placed after the policy became effective. *United of Omaha Life Insurance Co. v. Peloquin,* 660 So.2d 1069 (Fla. 4th DCA 1995).

Within the decision, the district court of appeal outlined that the trial court reviewed the dispute on a *de novo* basis, as had been requested by PELOQUIN. The appellate court determined that the unrefuted evidence demonstrated that PELOQUIN'S condition was present at all relevant times and was the cause for which she was receiving ongoing treatment and diagnosis at the time she had submitted an application to UNITED for insurance coverage. The appellate court found it unnecessary to render a decision involving a standard of review issue.

PELOQUIN requested rehearing in the District Court of Appeal, Fourth District of Florida, which was denied. Thereafter, PELOQUIN did *not* seek review in the Florida Supreme Court, which is the highest court of Florida in which a decision could be had in connection with this case. The absence of such attempt is reflected in PELOQUIN'S petition.

REASONS WHY THE PETITION SHOULD BE DENIED

From an historical perspective, the certiorari jurisdiction of this Court in connection with review of decisions in state court proceedings has been predicated upon the concept that such review would be limited to those decisions rendered by the *highest court* of the particular state court system. As can be seen from decisions such as *Fisher v. Perkins*, 122 U.S. 522, 7 S. Ct. 1227 (1887), when a decision of an intermediate state appellate court has been entered and procedures are available for seeking review with a higher state court, the failure to seek review and make application for review in the higher court precludes the complaining party from seeking entry into this Court. This Court cannot assume that the Florida Supreme Court would not have taken jurisdiction, and the failure of PELOQUIN to proceed further at the state level renders this Court without certiorari jurisdiction.

Article V, Section 1, and Article V, Section 3(b)(3) and (4) of the Florida Constitution outline the levels of the judicial system in Florida, including the relationship between district courts of appeal and the Florida Supreme Court. Review by the Florida Supreme Court as outlined in the Florida Constitution has been implemented in Rules 9.030(a)(2)(A), (iv), (v), and (vi), Florida Rules of Appellate Procedure. Rule 9.120, Florida Rules of Appellate Procedure, also outlines the procedures to be followed in connection with seeking discretionary review. In unmistakable terms, PELOQUIN had access to seek discretionary review in the Florida Supreme Court and whether such would have been successful or not is totally irrelevant for purposes of determining whether state remedies have been exhausted. This Court cannot assume

that the Florida Supreme Court would not have taken jurisdiction, and the failure of PELOQUIN to seek discretionary review renders this proceeding objectionable. *See, e.g., Mullen v. Western Union Beef Co.*, 173 U.S. 116, 19 S. Ct. 404 (1899); *Stratton v. Stratton*, 239 U.S. 55, 36 S. Ct. 26 (1915); *Matthews v. Huwe*, 269 U.S. 262, 46 S. Ct. 108 (1925); *McMaster v. Gould*, 276 U.S. 284, 48 S. Ct. 299 (1928); *Gotthilf v. Sills*, 375 U.S. 79, 84 S. Ct. 187 (1963); *Banks v. California*, 395 U.S. 708, 89 S. Ct. (1901), (1969).

Rule 13, Rules of the Supreme Court of the United States, reflects in its time schedule recognition of state court activity in the nature of seeking discretionary review. The time for filing a petition for writ of certiorari in connection with review of a judgment of a lower state court that is subject to discretionary review by the state court of last resort is calculated from the time the order is entered denying discretionary review. The purpose of the rule is to accommodate the principle of law that parties must exhaust their state court remedies, including seeking discretionary review in the court of last resort for a particular state. Here, the Florida Constitution and the Florida Rules of Appellate Procedure provide a mechanism for seeking discretionary review in the Florida Supreme Court, which was not attempted by PELOQUIN. The decision sought to be reviewed simply has not been rendered by the highest court of Florida in which a decision could be had in this case.

In addition to the foregoing, the decision of the District Court of Appeal, Fourth District, does not in any way decide a federal question under these circumstances. The intermediate appellate court specifically stated that it was not deciding the issue as to a trial court standard of

review, but merely reviewing that which the parties had requested the trial court to do. Where the decision does not decide federal issues or federal statutes, this Court should decline review. *See, e.g., WOW, Inc. v. Johnson*, 326 U.S. 120, 65 S. Ct. 1475 (1945); *McCoy v. Shaw*, 277 U.S. 302, 48 S. Ct. 519 (1928); *Honeyman v. Hanan*, 300 U.S. 14, 57 S. Ct. 350 (1937).

The argument presented by PELOQUIN fails upon proper legal analysis. The issue asserted by PELOQUIN involves consideration of the burden of proof in connection with a claim for insurance benefits. Under any circumstances, the plaintiff, such as PELOQUIN, had the burden of proof to demonstrate the entitlement to benefits. PELOQUIN fails to understand and deal with the concept that no matter what standard would be applicable to her, she failed because the uncontradicted evidence demonstrated that she was not entitled to benefits. The unrefuted testimony and evidence demonstrated that she was receiving active medical care prior to the issuance of an insurance contract for which she sought benefits after the policy was issued. Under any legal theory no recovery could be had.

PELOQUIN asserted at all times in the trial court that she was entitled to a *de novo* review in the case. PELOQUIN asserted such position because a *de novo* review standard would be most advantageous to her because she need only sustain a simple burden of proof of the greater weight of the evidence as would be applicable in any civil case. Such standard would place a lighter burden of proof upon PELOQUIN to prevail. Under the circumstances in this case, PELOQUIN did not and could not even sustain such limited burden of proof. The uncontradicted and

unrefuted evidence demonstrated that she was receiving active medical treatment prior to the policy, and such does not even take into account the fraud PELOQUIN attempted to perpetrate upon UNITED in the application process.

As an appellate afterthought, PELOQUIN sought to confuse the issues without understanding of the impact by making statements that she was entitled to a determination as to whether the decision to deny benefits was arbitrary and capricious. The impropriety of such argument and position can be recognized when it is understood that to satisfy a burden of proof demonstrating that a defendant has acted arbitrarily and captiously requires far more than merely demonstrating that PELOQUIN's position would be correct. If a claimant cannot sustain a *de novo* standard of review and burden of proof, then, most assuredly, the same evidence will not sustain a burden to show "arbitrary and capricious" behavior. PELOQUIN is asserting that a far more rigid standard was applicable to her case because she would have been required to demonstrate not only that the position of UNITED was incorrect, but that UNITED behaved arbitrarily and capriciously against her. Such standard of proof would place a heightened burden upon her, when PELOQUIN could not even sustain the simple burden of the greater weight of the evidence.

The very simple conclusion was recognized by the court below that PELOQUIN had nothing whatsoever to support her position, and no matter what standard would be applied in consideration of the evidence, PELOQUIN could not prevail. The appellate court merely accepted the standard as applied by the trial court which was

specifically requested by PELOQUIN, and when the evidence was considered, PELOQUIN could not sustain any burden of proof whatsoever. The lower intermediate appellate court has not rendered a decision concerning the standard of review applicable to cases, but has applied a standard in this particular case as specifically requested by PELOQUIN. It is inappropriate for PELOQUIN to now assert some type of error when the trial court followed that which PELOQUIN requested. Additionally, PELOQUIN had absolutely no evidence to support her position, and the unrefuted testimony demonstrated that her legal position was absolutely incorrect.

As outlined by this Court in *NLRB v. Pittsburgh S.S. Co.*, 340 U.S. 498, 71 S. Ct. 453 (1951), the certiorari remedy is intended and designed to be applied in connection with cases in which principles of law are of importance to the public as distinguished from being important simply to the parties involved in the litigation. Certiorari is reserved for those cases in which there has been a real and embarrassing conflict of opinions and authorities, and in this situation there is not even conflict when the factual circumstances are reviewed. Certiorari is not designed to satisfy the academic interest of PELOQUIN, particularly where the courts below have applied legal principles as requested by PELOQUIN.

CONCLUSION

The decision of the District Court of Appeal, Fourth District of Florida, as an intermediate appellate state court, fails to generate a basis for certiorari review. The Petitioner has failed to seek a decision or determination from the highest court in Florida, and this Court should not entertain jurisdiction.

Additionally, the court below applied unrefuted facts in accordance with standards requested by PELOQUIN which PELOQUIN now seeks to repudiate. No matter what standard of review would be applied under the circumstances in this case, the result would be the same. Here, a party does not recognize that she has requested the imposition of a higher burden of proof when such party could not even satisfy a lesser burden of proof. PELOQUIN could not establish by the greater weight of the evidence an entitlement to benefits, and certainly could not demonstrate that a refusal of benefits was arbitrary and capricious. The issue which PELOQUIN attempts to assert is truly a non-issue which PELOQUIN continues to ignore.

Respectfully submitted,

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REPLY

BRIEF

(3)

Supreme Court, U.S.
FILED
MAR 6 1996

95-1194

NO. ~~95-1195~~

In The

SUPREME COURT OF THE UNITED STATES

October Term, 1995

CHERYL M. PELOQUIN,

Petitioner,

vs.

UNITED OF OMAHA LIFE INSURANCE COMPANY, a Nebraska corporation,

Respondent.

APPEAL FROM A JUDGMENT OF THE CIRCUIT COURT OF THE 17TH JUDICIAL CIRCUIT IN AND FOR BROWARD COUNTY, FLORIDA, IN THE DISTRICT COURT OF APPEAL OF FLORIDA, FOURTH DISTRICT

PETITIONER'S REPLY TO BRIEF IN OPPOSITION

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8 pp

I. CONCERNING RESPONDENT'S ARGUMENT THAT THE DISTRICT COURT OF APPEAL WAS NOT "THE HIGHEST COURT" OF FLORIDA "IN WHICH A DECISION COULD BE HAD"

Respondent's contention that the Petitioner did not exhaust her state appellate remedies because there was a mechanism in place permitting application for review in the Florida Supreme Court is misconceived and without merit. Since codification of the rules respecting application to the Florida Supreme Court for certiorari, the Court's power to grant certiorari has been limited. In Robinson v. State, 132 So.2d 3 (Fla. 1961) the Court stated:

> [T]his Court no longer has extensive power to issue so called "common law writs of certiorari" to review judgments of lower courts. This power is now vested in District Courts of Appeal and Circuit Courts, by Article V, Sections 5 and 6, Florida Constitution. In situations in which review of a judgment or decree of a lower court is not otherwise provided for, the District Courts of Appeal are endowed with powers of review

limited to a determination of whether the judgment constitutes a deviation from the essential requirements of law. In a general way, this is the type of so-called common-law certiorari power exercised by this Court prior to the effective date of amended Article V, on July 1, 1957.

II. CONCERNING MISREPRESENTATIONS OF FACT CONTAINED IN RESPONDENT'S BRIEF IN OPPOSITION

1. Respondent's severally repeated assertion, made without citation to the record, that the Petitioner requested the trial court to apply a de novo standard of review is false, misleading, and without basis. As stated at page 5-6 of the Petition, the issue of the standard of review to be applied in the trial court was not directly raised or addressed by either party in the trial court proceedings.

2. Respondent's oft repeated assertion that the trial court applied a de novo standard of review is misconceived and illogically speculative. The court's

holding that there was no proper basis for the administrator's denial of benefits implicated application of an arbitrary and capricious standard of review. A decision without proper basis is necessarily arbitrary and capriciously rendered. At all events, the presumption of correctness mandates a holding that the proper standard of review was applied by the trial court.

3. Respondent's statement that the Petitioner was receiving medical care for the condition of endometriosis at the time the insurance contract was issued constitutes a distortion of the facts. Firstly, the record discloses that the parties stipulated that any diagnostic test and/or medicine taken (the so called "treatment") prior to the effective date of the policy was for abdominal pain, and not endometriosis. (T. October 28, 1993, page 7, line

23-25) R.218-220). Secondly, as the trial court found, abdominal pain could not, without more, be equated with endometriosis. Most importantly, the evidence which the Respondent alleges:

> ...demonstrated that PELOQUIN's condition was present at all relevant times and was the cause for which she was receiving ongoing treatment and diagnosis at the time she had submitted an application to UNITED for coverage (Brief in Opposition, page 5, second paragraph).

was evidence which was acquired after the final denial of benefits and which neither the trial court nor the appellate court could properly have factored into the calculus of their respective decisions, not being evidence which the plan administrator had before him/her at the time of making the denial.[1]

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[1] Review of a Plan Administrator's denial is limited to the evidence which the Plan Administrator had before him at the time the decision was made. Jett v. Blue Cross & Blue Shield of Alabama, 890

III. CONCERNING RESPONDENT'S STATEMENT THAT "THE STANDARD OF REVIEW IS IRRELEVANT TO THE ACTUAL DETERMINATION"

1. It cannot properly be contended that the standard of review to be applied was a matter of no consequence in the trial court. The standard of review is always relevant in reviewing an Administrator's denial of benefits.

2. In the case sub judicia the standard of review required by law to be applied was the arbitrary and capricious standard. Firestone Tire and Rubber Co. v. Bruch, 489 U.S. 101, 109 S.Ct. 948, 103, L.Ed.2d 80 (1989). As stated in II (2) above, the trial judges's arguments in support of his findings indicated that he applied the 'arbitrary and capricious'

F.2d 1137(11th Cir. 1990).

standard of review. [2] At all events, in accordance with the presumption of correctness, it must be so presumed. Based upon the findings of fact which the trial Judge made, and the standard of review which he presumably (and apparently) applied, the reviewing court could properly have reversed his decision only if there was an abuse of discretion. Determination of the standard of review applied by the trial court was therefore a necessary step in the review proceedings in the court of

[2] The judge stated:

> Look, you applied for an insurance policy, filled in your application. You put that you had headaches, you take aspirin for them, and then two years later they find a brain tumor ... why would [the insurance company] not be in a position to say, "wait a second. He had those headaches ... before we wrote this policy ... and now he wants us to pay off because he got a tumor in his brain. He should have known. He had headaches. (Record Vol. 4, Transcript of Proceedings taken on December 2, 1993, page 23)

appeal. Arguendo, had the trial judge mistakenly applied a de novo standard of review, then having regard to the findings of fact which he made, his decision must necessarily and inevitably have been the same, that is, that the Plan Administrator's denial of benefits was wrong.

Respectfully submitted,

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